## CLAIM FORM



Policy no.

Claim no.

GlobalExcel® Send your completed form to:

In CANADA: Global Excel Management Inc., 73 Queen Street, Sherbrooke, QC J1M 0C9 / In U.S.A.: Global Excel Management Inc., P.O. Box 10, Beebe Plain, VT 05823 IMPORTANT: Failure to sign both sides of this form will result in a delay of the processing of your claim.

SECTION		AIMA		ON (F	Please p	rint)						
PATIENT'S INFORMATION						POLICYHOLDER'S INFORMATION						
Last name	it name First i		iame		Initial	Last name		First name			Initial	
🗋 Male 🗖 Female		Date of birth (M/D/Y)		Address (number & street)			Date of birth (M/D/Y)					
	Self Sr Check if child		Dependent time student	/		City				Province	Postal code	
Provincial health		Home ( )			Work (	)						
Family physician & prior to the date of	& all other physic	Home ( ) Work ( ) Diagnosis of illness or injury (while travelling)										
Country where claim occured						Date of incident (M/D/Y)         Currency          /						
										Please indicate on each bill whether you have paid it or not.		
SECTION	И В ОТ	HER	NSURANCE INF	ORN	ΛΑΤΙΟΝ							
Patient's (or parent's) occupation:  Full-time employment  Self-employed  Student  Retired Other:												
Name of your em	ployer:											
						Suite no	City					
Provinc	e			Postal	code	Telephone	e (	)				
Name of spouse's	s employer:											
						Suite no						
						Telephone						
Employee group benefits plan:       Yes       No       Group policy no.       Name of covered person         Identification no.       Name of insurance company       Date of birth of insured (M/D/Y)       //												
				•		Name of the cardhold			•			
-						rior to your departure) bany/broker:		🗋 No				
Are you covered b	y US Medicare:	🗋 Yes	🔲 No 🏻 Plan no			Туре:		В	Both			
						N EXCESS OF YOUR PROVIN INT FROM THESE SOURCES,						
SECTION		THOF	RIZATION TO PH	IYSIC	CIANS, H	OSPITALS, AND (	THER N	NEDIC		OVIDER	S	
1. I, the undersigned, hereby authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management Inc., authorized representatives of the insurer. I further consent to the disclosure of this information by Global Excel Management Inc. to other sources as may be required to obtain benefits from other sources.						<ol> <li>I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed above).</li> <li>I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.</li> </ol>						
for covered loss Global Excel Man	bal Excel Managem es under this polic nagement Inc. wit	camit										
Patient's or aut	thorized perso	ı's sig	nature					_ Dat	e			
FOR COMPANY USE ONLY	Fraud Verificati	on A:				Fraud Verifi	cation B:					

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Your travel insurance plan provides coverage **in excess** of your provincial health insurance plan and any other applicable insurance. After reconciling eligible claims with the health care providers we must seek reimbursement through your provincial Health Ministry for a portion of the amount which we will have paid. In order to do so we must request that **you sign the Statement of Agreement & Understanding below.** 

## STATEMENT OF AGREEMENT & UNDERSTANDING:

I, \_\_\_\_\_\_, having read the above, agree to forward to Global Excel Management, Inc. any reimbursement received from my provincial health insurance plan, health number \_\_\_\_\_\_, for all claims paid by Global Excel Management Inc. and to exchange information that facilitates this process.

## CLAIMANT'S OR AUTHORIZED PERSON'S SIGNATURE

DATE \_\_\_\_\_

**Important:** Accurately completing all details will assist us in settling your claim promptly. Please attach original bills or receipts you may have in your possession. We recommend you keep copies for your own records.

## For claim, inquiries call: 1-800-336-9224 or 819-566-8698.